

FILED FEB 2 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3544

State File No. ....

BIRTH NO. ....		REG. DIST. NO. <u>323</u>		PRIMARY REG. DIST. NO. <u>6089</u>		Registrar's No. <u>2</u>	
1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mt. Leonard</u>		c. LENGTH OF STAY (in this place) <u>2 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mt. Leonard</u>		d. STREET ADDRESS (If rural, give location) <u>North part of town</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>North part of town</u>				d. STREET ADDRESS (If rural, give location) <u>North part of town</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Lewis</u> b. (Middle) <u>-----</u> c. (Last) <u>VanBuskirk</u>				4. DATE OF DEATH <u>Jan. 19, 1950</u> (Month) (Day) (Year)			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Jan. 2, 1876</u>	
9. AGE (In years last birthday) <u>74</u>		10. MONTHS <u>0</u>		11. DAYS <u>17</u>		12. IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Saline County, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13a. FATHER'S NAME <u>Samuel VanBuskirk</u>				13b. MOTHER'S MAIDEN NAME <u>Emma Driskell</u>		14. NAME OF HUSBAND OR WIFE <u>Nellie Pyle VanBuskirk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>491-07-7644</u>		17. INFORMANT'S SIGNATURE OR NAME <u>L.A. VanBuskirk Mt. Leonard Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Glomerulonephritis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cerebral Thrombosis</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 4 1950</u> , to <u>Jan 19 1950</u> , that I last saw the deceased alive on <u>1-17, 1950</u> , and that death occurred at <u>3 P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>C. A. Keatch M.D.</u> (Degree or title)				23b. ADDRESS <u>Marshall, Mo.</u>		23c. DATE SIGNED <u>1-20-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan. 21, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Antioch cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Saline County, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>1/23/50</u>		REGISTRAR'S SIGNATURE <u>Sally Andrew</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew Campbell</u>		ADDRESS <u>Marshall, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED  
District Health Officer No. 6,  
District File Number \_\_\_\_\_  
Date Filed 1-31-50

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Jan. H. Lewis*

Licensed Embalmer No. 1176

P. O. Address Marshall - Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.